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# Yolun Başı: Bir Tıp Fakültesi Özelinde Mesleklerarası Eğitime İlişkin Öğretim Üyelerinin Görüşleri

# Start of the Road: Views on Interprofessional Education among Faculty of a Medical School in Turkey

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**Özet**

**Amaç:** Meslekler arası eğitim (MAE), iş birliğini ve bakım kalitesini iyileştirmek için önemli bir pedagojik strateji olarak vurgulanmıştır. Bu stratejiyi içeren bir programı müfredata dahil etmeden önce, programın başlatılması, sürdürülebilirliği ve başarısı için eğitmenlerin program hakkındaki görüşlerini belirlemek önemlidir. Bu çalışmanın amacı Süleyman Demirel Üniversitesi Tıp Fakültesi (SDUSM) öğretim üyelerinin MAE'e ilişkin görüşlerini değerlendirmektir.

**Yöntem:** Nitel verilerin kullanıldığı tanımlayıcı tipteki araştırmada, yarı-yapılandırılmış görüşme yöntemi kullanılmıştır. SDÜTF'de görevli 185 öğretim üyelerine MAE hakkında bilgilendirme toplantısı düzenlenmiş ve 38 öğretim üyesi bu toplantıya katılmıştır. Çalışmanın örneklemi toplantıya katılan ve çalışmaya katılmaya gönüllü olan kişiler arasından rastgele seçimle belirlenmiş ve veri doygunluğuna ulaşılıncaya kadar görüşmeler devam etmiştir (n = 14). Görüşmelerin kayıtları yazıya dökülmüş ve nitel verilerin içerik analizleri dört uzman tarafından yapılmıştır. Tematik kodlama ve frekans dağılımlarının belirlenmesi için içerik analizinde MAXQDA yazılımı (sürüm 12) kullanılmıştır.

**Bulgular:** Öğretim üyeleri, MAE programlarının fizibilitesini, eğitim programı modellerini, MAE uygulamasının olumlu yönlerini ve uygulamanın önündeki engelleri ve bu uygulamaların tıp mesleğine olası katkılarını tartıştılar. Öğretim üyeleri MAE'in uygulanmasıyla ilgili çeşitli engellerden bahsettiler. Bununla birlikte, MAE yaklaşımının profesyonel hayata uyumu kolaylaştıracağını ve muhtemelen güçlü iletişim, empati ve takım çalışması becerilerine sahip iyi donanımlı ve kendine güvenen doktorlar yetiştirmeye yardımcı olacağını belirtmişlerdir.

**Sonuç:** Bu görüşler doğrultusunda MAE, SDÜTF'de uygulanabilecek bir eğitim yöntemi olarak düşünülebilir.

**Anahtar sözcükler:** Mesleklerarası Eğitim, Fakülte Üyeleri, Program Geliştirme

**Keywords:** Interprofessional Education, Faculty Members, Program Development

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***Abstract***

***Aim:*** *Interprofessional Education (IPE) has been emphasized as an important pedagogical strategy for improving collaboration and the quality of care. Before implementing this strategy to curriculum with a program it is important to determine the views of the instructors about the program, for its initiation, sustainability and success. The purpose of this study was to evaluate the opinions of faculty members in the Süleyman Demirel University School of Medicine (SDUSM) about IPE.*

***Methods:*** *This descriptive study used qualitative data obtained with the semi-structure interview method. Out of 185 faculty members, 38 of them attended an informative meeting about IPE. The sample group was established by random selection who volunteered to participate, interviews continued till the data saturation is observed (n=14). The recordings of the interview were transcribed and content analyses of the qualitative data were carried out by four experts. MAXQDA software (version 12) was used in content analysis for thematic coding and determining frequency distributions.*

***Results:*** *The faculty members discussed the feasibility of IPE programs, models of the educational program, the positive aspects and barriers of implementing IPE and its potential contribution to the medical profession. Faculty members mentioned several barriers related to the implementation of IPE. Also, they stated that the IPE approach would facilitate adaptation to professional life and possibly help produce well-equipped and self-confident doctors with strong communication, empathy, and team working skills.*

***Conclusions:*** *In line with these opinions, IPE can be considered as an educational method that can be implemented in SDUSM.*

## INTRODUCTION

The concept of fostering a team mentality to improve the quality of health care first emerged with the work of the General Practitioners Union in the 1960s and courses where practitioners and healthcare professionals from various disciplines were trained together, and the need for team awareness was first addressed in 1978 with the Declaration of Alma-Ata (1–3). Obstacles to interprofessional education (IPE) in this period included beliefs that different occupational groups educated on the basis of a single discipline may resist being a team, that it may not be possible to clearly define responsibilities and communicate effectively when providing care as a team, and that cohesion within professional groups may conflict with IPE due to the hierarchical nature of interprofessional relationships (1).

The World Health Organization (WHO) increased its emphasis on IPE in its 1988 report entitled "Learning Together to Work Together for Health" (2). This report defined IPE as "the process by which a group of students (or workers) from the health-related occupations with different educational backgrounds learn together during certain periods of their education, with interaction as an important goal, to collaborate in providing promotive, preventive, curative, rehabilitative and other health-related services." Initiatives around the world have increased in parallel with WHO, and those initiatives addressing IPE and its implementation were started on a volunteer basis and with regional applications. In 2006, the definition of IPE was revised by the Center for the Advancement of Interprofessional Education (CAIPE) as "occasions when two or more professions with to improve collaboration and the quality of care." As the benefits of this philosophy became apparent and studies were conducted on its positive outcomes, WHO published the Framework for Action on Interprofessional Education and Collaborative Practice in 2010 (3). This framework aimed to transform IPE into a global health policy by suggesting strategies and ideas that health policy-makers could use to integrate the principles of IPE and collaborative practice into their own local health systems (4).

The basic purpose of health services has been defined as improving the health of the patient while ensuring the maximum level of physical and emotional comfort. In areas where many different professional groups work together, the ability to act as a team has been determined to directly affect the service quality and reliability. In that sense, IPE has been emphasized as an important pedagogical strategy through which health professionals can learn to work as a team (5).

The reported benefits of IPE include improving patient care, fostering collaboration among health professionals, developing teamwork skills in the workplace, helping learners to better understand the professional roles of other health workers, sharing interprofessional knowledge, skills, and attitudes, and promoting respect for others' work and efforts (6).

The need for improved interprofessional collaboration and communication skills has been cited to ensure patient safety, and IPE can facilitate joint decision-making in patient care, which is an important step toward patient-centered approaches (7).

Lack of interprofessional communication among team members and failure to implement collaborative practice in health care provision may lead to avoidable errors and adversely affect the healthcare system and its outcomes (8). Therefore, as recommended by WHO, different countries have defined different policies regarding IPE, and various national and international organizations have been established to support these policies, such as The Network: Towards Unity in Health (TUFH, 2012), the Center for the Advancement of Interprofessional Education (CAIPE, 2012), the European Interprofessional Education Network (EIPEN, 2012), the Canadian Interprofessional Health Collaborative (CIHC, 2009), the International Association for Interprofessional Education and Collaborative Practice (InterEd, 2012). IPE approaches have also been incorporated into accreditation standards. IPE is currently compulsory in Canada and the UK, and has been adopted as a prominent educational approach in Japan, the USA, and Australia (9–11).

In the field of health education, IPE approaches are currently being implemented to various degrees in the health education curricula of many countries. A review of the literature shows that although IPE organizations have their own guidelines, there have been some barriers to implementation. One of the reported barriers is the need to reach a large number of students due to the fact that IPE involves numerous health professions. This problem also raises several issues, such as difficulty providing funding for continuing education, the need to establish a suitable physical infrastructure, the relative scarcity of qualified educators, and the need to ensure program synchronization so that all professionals receive the same education (12–14). Proposed solutions to these problems are to provide administrative support and funding if conventional educational settings will be created, or to employ modern technology and utilize distance learning environments (14).

Another barrier mentioned in the literature is the perceptions of occupational value attributed to different professionals (5,15). These potential differences in attitude among management, faculty, and students are reported to be one of the most critical barriers facing IPE as an educational approach (16). In particular, negative perceptions related to this issue among faculty members acting as instructors or directors in the program may be unintentionally transferred to the students as part of the hidden curriculum through their behavior and nonverbal communication, resulting in the students receiving wrong messages (17). In addition to differing attitudes, other barriers that contribute to faculty members' negative perceptions of IPE include not seeing the necessity of these training approaches, their level of knowledge on the subject, and reluctance to be involved in the program due to increased workload and time constraints (5).

It has been reported that whether faculties support this educational approach and embrace the change or efforts are being made to meet accreditation criteria, the management is responsible for providing the motivation to change, and the faculty members involved in the program must be appreciated and encouraged to recognize its necessity (5). Some have claimed that the program cannot be implemented effectively if there is any instructor who does not believe in IPE as an educational approach. In practice, it has been observed that attitude-related barriers are much more resistant than administrative, financial, and organizational ones, and have lead to short-term failure in faculties attempting to implementing IPE (18,19). Therefore, implementation can be facilitated and the likelihood of success improved by conducting needs analyses in the program development phase, assessing perceptions and readiness among stakeholders who will be involved in the program, performing SWOT (strengths, weaknesses, opportunities and threats) analysis to predict potential obstacles, and identifying feasible solutions to those barriers (19,20).

The purpose of the present study was to evaluate the opinions of faculty members in the Süleyman Demirel University School of Medicine (SDUSM) regarding IPE as an alternative educational approach.

## METHODS

The study was conducted with permission from the SDUSM Clinical Research Ethics Committee (approval number 45, date: 07.03.2018).

This descriptive study used qualitative data obtained with the semi-structure interview method. This method is not as restricting as fully structured interviews or as flexible as unstructured interviews (21). The semi-structured interview technique was preferred because it provides this flexibility to the researcher. Prior to the study, national and international literature was reviewed, interview questions were prepared, and expert opinions were obtained to prepare the semi-structured interview form (Table 1).

**Table 1.** Semi-Structured Interview Form

| |
|---|
| **START OF THE ROAD: VIEWS ON INTERPROFESSIONAL EDUCATION AMONG FACULTY OF A MEDICAL SCHOOL IN TURKEY**<br>**IN-DEPTH INTERVIEW FORM** |
| **Research Question:**<br>What are medical school faculty members' views on interprofessional education? |
| **Place:** **Date and time (start–end):**<br>**Interviewer:** **Interviewer:** |
| **INTRODUCTION**<br>My purpose in this interview is to learn the views of faculty members regarding Interprofessional Education. I hope that the results of this study will help determine the feasibility of interprofessional education in the field of health sciences. Therefore, I would like to hear your opinions about interprofessional education as well as your experiences and recommendations, if any.<br>The statements you make in this interview will remain confidential. It is not possible for this information to be viewed by anyone other than the researchers. In addition, the names of the interviewees will definitely not be disclosed in the research report. Do you have any questions about this?<br>Would you like to say or ask anything before we start our interview?<br>I would like to record our voices during the interview in order to correctly remember your responses and ensure reliability of the results. Do you mind if I do that? If you wish, I can send you the transcript of the interview within a few days for you to check and I can delete any information you want to omit.<br>I expect this interview to take about 30 minutes. With your permission, I'd like to start the interview. |

**Personal Details:**

Your age:
Your gender:
Your branch:
Your position:
Years of experience:

1. Did you know about interprofessional education before the informational session you attended? YES ( ) NO ( )
   - If yes, can you tell me about the source of this information? (Education, attending a course, reading, hearing from others, etc.)
   - When was it?
   - How long was it?
   - Where was it?
   - Who provided the education/training?
   - Can you tell me about the nature of the education/training? (Theoretical education and/or practical training)
2. What are your thoughts about conducting education on common subjects collectively with different disciplines in the period before graduation?
   - What is your opinion about the importance of interprofessional education?
   - What do you think about the feasibility of interprofessional education?
   - How can interprofessional education be realized?
3. What disciplines can be included in an interprofessional education program implemented in the field of health?
4. To what level of student is an interprofessional education in the field of health applicable?
5. What skills do you think individuals from different disciplines could gain or develop through collaborative work?
   - Teamwork and team-based practices
   - Roles and responsibilities for collaborative work
   - Ethics and values for interprofessional practice
   - Communication
6. What educational features should an interprofessional education program have?
7. What kinds of problems may arise in the implementation of an interprofessional education program?
   - How can these problems be solved?
   - How do you think an interprofessional education program can be successful?
8. How might an interprofessional education program be reflected in medical practice?
9. Would you like to be involved in the process of developing an interprofessional education program?

The universe of the study consisted of SDUSM faculty members (N=185). Of these, 38 faculty members attended an informative meeting about IPE. The sample group was established by random selection from among basic sciences, internal sciences, and surgical sciences faculty who volunteered to participate, and the interviews continued until the data saturation was reached (n=14). Data saturation criteria were taken into consideration when determining the sample size.

Appointments were made with the participating faculty members in settings that would allow them to express themselves freely, and face-to-face interviews were conducted using the semi-structured interview forms. Permission to record the interview (audio only) was obtained from each participant before beginning. These recordings were then transcribed in a digital

environment and submitted to the faculty for their review and approval.

Content analyses of the qualitative data were carried out by four experts. MAXQDA software (version 12) was used in content analysis for thematic coding and determining frequency distributions.

**RESULTS**

Of the 14 faculty members in the study, 57.1% (n=8) were men, the mean age was 40.57 years (33–53 years), and the mean length of time practicing medicine was 16.57 years (9–29 years). The distribution of the participants' branches and titles are presented in Table 2.

**Table 2.** Distribution of The Participants' Demographic Characteristics

| | | Frequency | Percent (%) |
|---|---|---|---|
| **Department** | Basic Science | 3 | 21,4 |
| | Internal Science | 7 | 50,0 |
| | Surgical Science | 4 | 26,8 |
| **Academic Title** | Profesor | 5 | 35,7 |
| | Asociate Profesor | 1 | 7,1 |
| | Assistant Profesor | 8 | 57,1 |

When questioned about their prior knowledge of IPE, 85.7% (n=12) of the faculty stated they did not know about the concept and had never had training on the subject, while 14.3% (n=2) had heard of the concept before but did not know enough about it.

As for their views on its feasibility, the faculty stated that IPE could be implemented. However, they stated that it should take place toward the end of the educational curriculum and that psychological, cultural, and economic issues that could lead to problems must be resolved.

> *"…personally, I believe it is feasible, but as a prerequisite, students in each discipline should first have basic education in his/her own field before receiving such training in the last one or two years of education, depending on the school." (P=7)*

> "*I think it is absolutely very functional and important and something that I needed a lot in practice, but in terms of implementation, it requires serious infrastructure to achieve the things I have in mind. It may be a problem financially…"* (P=12)

It was stated that in the planning phase, members of occupational groups working in the medical school hospital in particular should participate together in IPE.

> *"Nurses, physical therapists, radiology technicians, operating room personnel and dentists can be included as well, but first should be the people who work in this hospital, maybe audio metricians, psychologists, I think there are physicists... there are personnel, medical personnel." (P=13)*

Several faculties stated that IPE could be implemented during clinical rotations before graduation from the medical school. This was justified by saying that members of a professional group must first learn the roles and responsibilities of their own profession and then they can work more productively as part of a team.

*"…for each faculty, I think the students should have completed at least the basic level of professional education… Nurses already start intrahospital practice during their education, under the name of practical application. This stage can be collaborative, I mean it can be implemented at this level." (P=2)*

It was stated that individuals from different disciplines and levels of seniority could be instructors in the program. Emphasis was placed on the instructors having effective communication, being positive role models, having high motivation regarding education, and being aware of the importance of IPE.

*"The teachers should be good role models… The students will watch every interaction the instructor has with all health professionals second by second, like watching a film. Students must be able to watch an instructor's day, in my opinion…. [the teacher] must be fully focused on their job, dynamic, have strong observation skills; after all, they are expected to be the expert of the group, be a guide, they should not intervene but be directive." (P=8)*

Educational methods recommended for IPE were student observations, theoretical knowledge, role playing, simulation, and practicing on real patients. It was also noted that previous implementations could be used as examples.

*"Students must be able to watch an instructor's day, in my opinion. Later they will watch, not only medical students but also nursing and technician students will watch. They will have questions in their minds. Later you will take these students and put them together, if you are going to teach any theoretical knowledge then we teach it, then the students do simulations, then with real patients, and step by step they will do things like what their instructors do. They must be given responsibility and also, they have to fulfill it. They will show it, you know?" (P=8)*

The faculty members stated that IPE would reinforce communication between different professional groups, develop empathy, foster respect, and acceptance, raise team awareness, and support cooperative learning, thereby benefiting patients and increasing the quality of health care services.

*"…mutual interaction develops the culture of collaboration. An environment of mutual communication can be created. Everyone shares his/her education with the other professional groups… On the other hand, we already work together with midwives and nurses, having such training with them may create a culture of teamwork. It contributes more to that part, develops that perception" (P=7)*

*"…our awareness is raised, I mean, we become more aware because we have a better understanding of what the other team does to get results and we can achieve the goal in a shorter time, we can succeed more quickly. Likewise, whoever else we come into contact with, we definitely learn something through that contact. And the gaps in our learning resulting from their absence in the education program are filled?" (P=6)*

In the interviews it was stated that a medical student that receives IPE can become a well-equipped and self-confident physician who can be an effective team member in professional life, has strong communication and empathy skills, that adapting to professional life will be easy for them, and that these benefits will reflect positively in patient care.

*"…they would become a good doctor, I think they can be a multidisciplinary doctor, who is experienced, well-rounded, can do any task… skillful and well-rounded" (P=4)*

*"…they will be self-confident the moment they enter a hospital and adapt very easily. This education would contribute to*

*their success at work. We all experienced many traumatic things at the beginning of our professional life, some of us even quit. The adaptation period would be much easier, their self-confidence would be higher, patients would benefit, it would show in patient care." (P=8)*

Despite the aforementioned benefits and positive contributions to the profession, participants also cited certain barriers to the implementation of IPE. Of these barriers, interprofessional hierarchy, instructors' and students' previous negative experiences and resulting prejudices, inequality between health care professionals in terms of social perceptions and the healthcare system and the resulting professional ego, low awareness due to the inadequate readiness and prior knowledge of instructors and students, and their reluctance to be involved in this "novel" approach were identified as threats to the planning of IPE. Participants stated that even if there was intention to develop such an education program, implementation may be threatened by bureaucratic obstacles that would be encountered in harmonizing various faculties' programs and when planning the program, as well as by the heavy workload of the instructors. Other concerns expressed were that instructors' lack of knowledge about the subject would be reflected in the education, and there may be clashes of authority and conflicts among the students. It was stated that these barriers would impact the effectiveness of IPE, and interactive learning would be superseded by unidirectional learning.

*"The ego says, 'When I get into medical school it's like I already graduated from nursing or vocational school [medical students have higher university entrance exam scores than nursing and midwifery students]' …because medical students always get this ego... Our nurses also achieve great things... but physicians are not aware of it at all." (P=1)*

*"…this is actually something related with how society views the health sector. For once, people should understand and agree that all health professionals are valuable to society. However valuable physicians are here, the nurses also provide just as valuable a service... if personal rights can also be similarly brought to a certain level among the professions, social perceptions may change" (P=3)*

*"…bringing together students from different faculties is not easy in terms of scheduling." (P=11)*

## DISCUSSION

This study was conducted to evaluate the views of faculty members in the SDUSM regarding IPE as an alternative educational approach. During the in-depth interviews, the participants discussed the feasibility of IPE programs, models of the educational program to be planned for Turkey and SDUSM, the positive aspects of implementing IPE and its potential contribution to the medical profession, and barriers to the implementation of this program.

Though IPE as a concept was born in the 1960s, the need to include it in health education curricula as an educational strategy was proposed in 2010 in the Framework for Action on Interprofessional Education and Collaborative Practice issued by WHO. It has been implemented for many years as an important educational strategy in global health education (4). In Turkey, the practice of IPE has been limited to local applications in some faculties (22). Therefore, the concept is not well known among health academicians and students. We also found in the present study that the faculty members did not know about IPE. Similar levels of prior knowledge and experience have been observed in international studies conducted in faculties that do not actively utilize IPE in their curricula and are transitioning to this educational approach (23). Because instructors' lack of prior knowledge

may be a barrier to the implementation of IPE programs, previous reports have emphasized the importance of completing the necessary 'train the trainer' interventions during program preparation (24).

Motivation of both instructors and students is important to ensure the sustainability of IPE programs. Instructors having a positive attitude toward the unfamiliar area of IPE and ensuring their mental readiness have been described as a prerequisite in the literature (23). Consistent with other studies, we also identified low awareness among instructors and students and their reluctance to be involved in this "new" approach due to lack of readiness and prior knowledge as among the potential barriers that may threaten the planning of IPE.

The IPE approach has been reported to have positive effects on patient safety and recovery. Scientific studies have also supported the necessity for those who work or who will work as part of a team to be aware of this when they are studying in the program. However, it is often emphasized that there are certain obstacles to the implementation IPE programs. Our study also yielded similar results. According to the literature, one of the greatest obstacles to the implementation of IPE is the attitudes toward IPE among people who are from different disciplines and whose education involved different strategies. Consistent with other studies (26-28), we observed that faculty members had positive attitudes about IPE, they believed that the development of the program would have a favorable impact on the medical profession, and they also expressed positive views regarding its feasibility. In addition, although it has also been noted that there may be negative opinions, attitudes, and behaviors toward different professionals, Daloğlu and Şenol (2018) examined the origins of the nursing and medicine professions in particular and stated that some habits rooted in the past may be negatively reflected in IPE and practice (25). Similarly, social and hierarchical reasons have been reported as possible threats to IPE (26).

In a faculty where the instructors are found to have positive attitudes towards IPE and sufficient readiness, the main barrier to implementation is believed to be harmonization of the work schedules of instructors and members from different faculties (27). In our study we also observed prejudice that bureaucratic obstacles encountered in the preparation process and the instructors' heavy workload would be threats to the feasibility of the program. Benett et al. (2011) reported in their study that there may be a conflict of authority among faculties with regard to time, schedule, infrastructure, program operation, and student assessment, and that therefore a leader may be needed for the implementation of IPE (28). The instructors that we interviewed also stated that there may be clashes of authority resulting in conflicts among students. Concerns that the negative experiences students could have during their educational activities may be transferred to their professional lives have also been emphasized in other studies (28). Instructors in these programs have been described in the literature as three different categories: *IPE champion* (strategic and operational advocate(s) and leader(s) who generally spearhead the incorporation of an IPE component into the curriculum); *IPE professional leader* (one or more individuals appointed by professional bodies who can represent each profession and present its characteristics in the planning phase), and *IPE facilitator* (people involved in the educational activities who can direct student learning and provide appropriate feedback in the IPE applications) (19,29,30). In our study, faculty emphasized that people from different disciplines and seniority levels could be instructors in the program, as long as they have "educator" qualities and awareness of the importance of IPE.

Another issue discussed in our study was which disciplines will be included in the program to be

developed. It was stated that priority should be given to the professional bodies within the same training hospital and that the program could be extended to encompass other fields if needed. In the literature it can be seen that IPE programs are planned primarily among the professionals likely to work together in the course of patient care (19,30,31).

The faculty members in our study expressed that in terms of students' development of professional roles and responsibilities, the best time to incorporate IPE programs into the curriculum is the final years of study before graduation, when the students receive "clinical training." Although there are previous studies that suggest students must first learn the roles and responsibilities of their own profession and can work more productively in a team only after having developed their professional identities, it has also been observed that upon assuming their professional roles, they are more prone to act as guardians of the profession and 'otherize' in a team. Therefore, starting IPE in the early years of study may be an alternative (32,33).

Studies have indicated that IPE reinforces interpersonal communication and facilitates recognition of other professions' roles (5,24). Similarly, the faculty members in our study stated that IPE would make positive contributions in terms of communication, empathy, respect, acceptance, and having a team mentality. Moreover, in accordance with the rationale behind the global emergence of IPE, it was emphasized in our study that IPE would support collaborative learning and increase the quality of health care services, thereby benefiting the patient.

## CONCLUSIONS

When developing educational programs, it is important to determine the views of the instructors involved in the program for its initiation, sustainability, and success. In this study, faculty members in the role of instructor mentioned several difficulties and barriers related to the implementation of IPE. On the other hand, they stated that the IPE approach would facilitate adaptation to professional life and possibly help produce well-equipped and self-confident doctors with strong communication, empathy, and teamworking skills, which would subsequently make a positive impact on patient care. Therefore, they expressed opinions in favor of applying the IPE approach in our faculty. In line with these opinions, IPE can be considered as an educational method that can be implemented in SDUSM.

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***Conflict of Interest***

No authors have any conflict of interest.

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